BAPTIST HEALTH®

MEDICAL GROUP

Patient Information Packet

Preferred Procedure:

- ❍ Laparoscopic Adjustable Gastric Banding
- ❍ Laparoscopic Roux-en-Y Gastric Bypass
- ❍ Revision-Previous Weight Loss Surgery
- ❍ Laparoscopic Sleeve Gastrectomy
- ❍ One Anastomosis Gastric Bypass (OAGB)
- ❍ Self-Pay Surgical Options Available

Are you able to read, write and communicate in the English Language? ❍ YES ❍ NO

If not, what is your primary language?_____

Please list any other barriers to communication, or special accommodations that you require: _____

Patient Information

First Name:_____ Middle Name:_____ Last Name:_____

Social Security Number:_____ Date of Birth:_____ Age:_____ Gender: ❍ Female ❍ Male

Marital Status: ❍ Married ❍ Single ❍ Divorced ❍ Separated ❍ Partnered ❍ Widow

How many children do you have (please list ages)?_____

Ethnicity: ❍ African American ❍ Hispanic ❍ Native American or Alaska Native ❍ Choose not to specify

❍ Asian ❍ Caucasian ❍ Native Hawaiian / Other Pacific Islander ❍ Other:_____

Religious affiliation:_____ Patient's level of Education:_____

What is your height?_____ft. _____in How much do you weigh?_____lbs. BMI:_____

Address Information:

Street Address:_____

City:_____ State:_____ Zip Code:_____

E-mail:_____ Phone (home):_____

Phone (work):_____ Phone (cell):_____

Patient Employment Information:

Employment status: ❍ Full Time ❍ Retired ❍ Disabled ❍ Student

❍ Part Time ❍ Unemployed ❍ Homemaker ❍ Leave of Absence

Patient's Current Employer:_____ Years Employed:_____

Patient's Employer's address:_____

Patient's Present or Former Occupation:_____

Disabled? ☐ Yes ☐ No If Yes, specify the year and cause: Year:_____ Cause:_____

Can you walk unassisted? ☐ Yes ☐ No How far before needing rest?_____ (Approximate # of feet)

If you need assistance walking, what device(s) do you use? ☐ Cane ☐ Walker ☐ Crutches ☐ Other:_____

Are you wheelchair bound and unable to stand at all? ☐ Yes ☐ No How long in wheelchair?_____ (Month/year)

Do you have a Medical Surrogate, Power of Attorney, healthcare companion/caretaker, or anyone who makes your medical decisions?

☐ YES ☐ NO If yes, who?_____Relationship to you?_____

Do you have a living will? ☐ YES ☐ NO

Please provide the office with a copy of any legal documentation pertaining to the above questions.

Spouse Information

Spouse's Name:_____ Spouse's Date of Birth:_____

Spouse's Employment Status: ❍ **Full Time** ❍ **Retired** ❍ **Disabled** ❍ **Student**
❍ **Part Time** ❍ **Unemployed** ❍ **Homemaker** ❍ **Leave of Absence**

Spouse's Occupation:_____ Spouse's SSN:_____

Spouse's Employer:_____ Years Employed:_____

Spouse's Employer's address:_____ Spouse's Cell Phone:_____

Insurance Information – (This section must be filled out in addition to sending in a copy of your insurance card)

Payment Type: ☐ Insurance ☐ Self Pay

Primary Insurance

Insurance Company:_____

Policy Number:_____ Group #:_____

Subscriber Name:_____ Subscriber Date of Birth:_____

Customer Service Phone:_____ Provider Phone:_____

Secondary Insurance

Insurance Company:_____

Policy Number:_____ Group #:_____

Subscriber Name:_____ Subscriber Date of Birth:_____

Customer Service Phone:_____ Provider Phone:_____

Emergency Contact

First Name:_____ Last Name:_____

Relation to you:_____Phone:_____

"I hereby authorize Baptist Health Medical Group to discuss my process, diagnostic test results and any scheduled appointments with the following named person(s), and further consent to the staff leaving messages for me on a voicemail/answering machine":

Name:_____ Relation to you:_____

Name:_____ Relation to you:_____

Patient Signature:_____ Date:_____

Primary/Referring Physician

First Name:_____ Last Name:_____

Street Address:_____

City:_____State:_____ Zip Code:_____Phone:_____

Have you discussed Weight Loss Surgery with your physician? ☐ Yes ☐ No Is your physician supportive? ☐ Yes ☐ No

How did you hear about us? ☐ Radio ☐ TV ☐ Newspaper ☐ Family/Friend ☐ Internet ☐ Other:_____

Please list any specialists/ providers that you currently see: ☐ NONE

Name	Specialty	Address/phone

Blood Consent

You must be willing to accept blood or blood products during or after surgery if your condition is such that the physician deems it necessary. (*☐ If Jehovah's Witness please check)*

Patient Signature:_____ Date:_____

Weight Loss History

How long have you been overweight?_____Years How long have you been 35 pounds overweight?_____Years

How long have you been 100 pounds or more overweight?_____Years When did you start dieting?_____Age

Have you ever had a "stomach stapling" or other gastric restriction procedure? ☐ Yes ☐ No

(If yes, please provide this information when entering in your previous surgical history)

What is the most weight you have ever lost on a single diet?_____Lbs. How did you lose the weight?_____

How long did you sustain the weight loss?_____ ☐ No diet attempts of any kind

Check all that apply:

Unsupervised Diet Attempts: ☐ NONE

☐ Body for Life/Bill Phillips	☐ High Protein	☐ Low Fat	☐ Cabbage Soup
☐ Pritikin	☐ Stillman Diet	☐ Mayo Clinic	☐ Fasting
☐ Gloria Marshall	☐ Herbal Life	☐ Calorie Counting	☐ Scarsdale
☐ Richard Simmons	☐ Sugar Busters	☐ Atkin's Diet	☐ Slim Fast
☐ Health Spa	☐ Low Carbohydrate	☐ South Beach	☐ Other:_____

Supervised Diet Attempts: ☐ NONE

☐ Nutri-System	☐ Overeaters Anonymous	☐ Weight Watchers	☐ Jenny Craig
☐ TOPS	☐ Optifast	☐ HMR	☐ DASH
☐ LA Weight Loss	☐ Diet Center	☐ Other:_____	

Over-the-Counter or Prescribed Medications for Weight Loss: ☐ NONE

☐ Acutrim	☐ Dexatrim	☐ Ionamin/Adipex	☐ Phendiet	☐ Prozac
☐ Wellbutrin	☐ Amphetamines	☐ Didrex	☐ Tenuate	☐ Phentrol
☐ Redux	☐ Byetta	☐ Plegine	☐ Sanorex	☐ Meridia
☐ Xenical	☐ Diuretics	☐ Pondimin	☐ Phenteramine	
☐ Fen-Phen,				

# of months:_____ ☐ Other:_____

Behavioral Treatments for Weight Loss: ☐ NONE

☐ Hospitalization	☐ Hypnosis
☐ Physical Therapy	☐ Psychological Therapy
☐ Residential Programs	☐ Other:_____

Exercise: ☐ NONE

☐ Walking/Running	☐ Stationary cycle or treadmill
☐ Swimming	☐ Weight Training
☐ Team Sports	☐ Other:_____

Eating Habits, Do you:

Snack between meals? ❍ Yes ❍ No

Eat a lot of sweets? ❍ Yes ❍ No

Drink caffeine-containing drinks? ☐ Yes ☐ No

- If yes, how many cups per day?_____

Eat large meals? (gorge) ❍ Yes ❍ No

Drink carbonated beverages/soda? ❍ Yes ❍ No

- If yes, how many cans/bottles per day?_____

Have you used any of the following to control your weight? (Check all that apply)

☐ Binging and Purging ☐ Binging followed by food restriction ☐ Vomiting

☐ Excessive Exercise ☐ Excessive Calorie Restriction/Fasting

If so, when and how long was this period of behavior? _____

Do you currently force yourself to vomit after eating? ☐ Yes ☐ No

Why do you feel you eat? ☐ Physical Hunger ☐ Loneliness ☐ Anxiousness ☐ Makes me happy ☐ Bored

What reasons do you feel contribute to your weight? ☐ Over Consumption ☐ Inactivity ☐ Emotional Wellbeing

What else contributes to your weight struggle, i.e. how/why you have been unable to lose weight and/or maintain?

_____

_____

_____

Please tell us how your weight is interfering with your health and life?

_____

_____

_____

Why are you seeking weight loss surgery?

_____

_____

_____

Please tell us why you feel you can be successful with weight loss surgery?

_____

_____

_____

If you use eating as an emotional outlet, what will you substitute when your eating is restricted?

_____

_____

Medical History/Review of Symptoms: (Check all that apply)

General: ☐ **NONE**

☐ Fevers ☐ Weight Gain ☐ Tired / No Energy

☐ Night Sweats ☐ Insomnia ☐ Hair Loss

☐ Appetite Change ☐ Other:_____

Head and Neck ☐ **NONE**

☐ Wear contacts / glasses ☐ Vision Problems ☐ Hearing Problems

☐ Sinus Drainage ☐ Nose Bleeds ☐ Hoarseness

☐ Dentures, Partial / Full ☐ Allergies ☐ Glaucoma

☐ Regular Ear Infections ☐ Blurred / Double Vision ☐ Other:_____

Cardiovascular ☐ **NONE**

☐ Heart Attack ☐ Chest Pain w/ Activity ☐ Rhythm Changes

☐ Congestive Heart Failure ☐ High Blood Pressure ☐ Palpitations

☐ Varicose Veins ☐ Shortness of Breath on Exertion ☐ Ankle Swelling

☐ Ankle / Leg Ulcers ☐ Elevated Triglycerides ☐ Phlebitis / DVT

☐ Clogged Heart Arteries ☐ Rheumatic Fever / Valve Damage / MVP ☐ Rapid Heart Beat

☐ Irregular Heart Beat ☐ Cramping in legs when walking ☐ Heart Murmur

☐ Atrial Fibrillation ☐ Elevated Cholesterol ☐ Other:_____

Respiratory ☐ **NONE**

☐ Asthma ☐ Emphysema / COPD ☐ Bronchitis

☐ Pneumonia ☐ Chronic Cough ☐ Shortness of Breath at Rest

☐ Use of CPAP / BiPAP ☐ Use of Oxygen ☐ Snoring

☐ Pulmonary Embolism ☐ Sleep Apnea ☐ Had a sleep study; when:_____

☐ Other:_____

Gastrointestinal ☐ **NONE**

☐ Heartburn ☐ Hiatal Hernia ☐ Ulcers

☐ Diarrhea ☐ Blood in Stool ☐ History of elevated Liver Enzymes

☐ Constipation ☐ IBS (irritable bowel syndrome) ☐ Umbilical Hernia

☐ Difficulty Swallowing ☐ Hemorrhoids ☐ Fissure / Polyps

☐ Rectal Bleeding ☐ Black, Tarry Stool ☐ Ventral Hernia

☐ Abdominal Pain ☐ Enlarged Liver ☐ Cirrhosis / Hepatitis

☐ Gallbladder Problems ☐ Jaundice ☐ Pancreatic Disease

☐ Nausea / Vomiting ☐ GERD ☐ Incisional Hernia

☐ Barrett's Esophagus ☐ N A F L D / N A S H ☐ Other: _____

Bladder/Kidney ☐ **NONE**

☐ Kidney Stones ☐ Blood in Urine ☐ Prostate Problems

☐ Kidney Failure / Renal Insufficiency ☐ Leaking urine w/ cough/laugh/sneezing ☐ Men: PSA test in last year?

☐ Overall Loss of Bladder Control ☐ Urinary Urgency/Frequency/Pain/Burning ☐ Other: _____

Gynecologic (for women only) ☐ **NONE**

☐ Problems Conceiving / Infertility ☐ Currently Pregnant ☐ Uterine / Ovarian Cancer

☐ PCOS ☐ Menstrual Irregularity ☐ Menstrual Pain

☐ Excessively Heavy Periods ☐ Plan to have more children ☐ Post-Menopausal

Current method of birth control: _____

How many pregnancies have you had:_____ Date of Last Pap Smear?_____

How many miscarriages or abortions have you had:_____ Date of last menstrual period?_____

Breast ☐ **NONE**

☐ Nipple Discharge ☐ Lumps / Fibrocystic Disease ☐ Other:_____

☐ Pain ☐ Cancer Date of last Mammogram: _____

Musculoskeletal ☐ **NONE**

☐ Shoulder Pain ☐ Neck Pain ☐ Elbow Pain

☐ Hip Pain ☐ Wrist Pain ☐ Back Pain

☐ Foot Pain ☐ Knee Pain ☐ Ankle Pain

☐ Plantar Fasciitis ☐ Heel Pain ☐ Ball of Foot Pain

☐ Broken Bones ☐ Carpal Tunnel Syndrome ☐ Lupus

☐ Muscle Pain / Spasm ☐ Sciatica ☐ Rheumatoid Arthritis

☐ Fibromyalgia ☐ Osteoarthritis ☐ Other: _____

Neurologic ☐ **NONE**

☐ Balance Disturbance ☐ Dizziness ☐ Restless Leg Syndrome

☐ Stroke ☐ Seizures or convulsions ☐ Weakness

☐ Knocked Unconscious ☐ Numbness / Tingling ☐ Multiple Sclerosis

☐ Pseudo tumor Cerebri (loss of vision from high pressure in brain) ☐ Other:_____

Psychiatric ☐ **NONE** **Are you currently under the care of a mental health provider? ☐ Yes ☐ No**
If yes, please provide name & phone number: _____

☐ Depression/Anxiety ☐ Hospitalized for psychiatric problems When:_____

☐ Bipolar Disorder ("manic-depression") ☐ Attempted suicide When: _____

☐ Alcoholism / Substance Abuse ___ Past? ___ Present? ☐ Experience Suicidal Ideation When: _____

☐ Been in a chemical dependency program When: _____ ☐ Inflicted self-harm When: _____

☐ Schizoaffective disorder ☐ Victim of Mental/Emotional/Sexual/Physical Abuse

☐ Borderline Personality Disorder ☐ Other:_____

Endocrine ☐ **NONE**

☐ Parathyroid ☐ Hypothyroid ☐ Goiter

☐ Low Blood Sugar ☐ Excessive Thirst ☐ Endocrine Gland Tumor

☐ "Pre-Diabetes" ☐ Diabetes (Diet or Pills) ☐ Diabetes (Insulin Shots)

☐ Abnormal Facial Hair ☐ Excessive Urination ☐ Gout

☐ PCOS ☐ Other: _____

Blood/Lymphatic ☐ **NONE**

☐ Low Platelets (thrombocytopenia) ☐ Anemia ☐ HIV / AIDS

☐ Bruise Easily ☐ Lymphoma ☐ Swollen Lymph Nodes

☐ Bleeding/Clotting Disorder ☐ Blood thinning medicine use ☐ History of DVT / PE

☐ Prior blood Transfusion ☐ Other:_____

List Prescribed Medications:	**Taken for what condition:**	**Dosage/How Often:**
☐ **NONE**		

Current Pharmacy:	**Address:**	**Phone #**

List any Over-the-Counter medications, herbal supplements or vitamins that you take on a regular basis.

Product:	**Taken for what purpose:**	**Dosage/How Often:**

Allergies ☐ **NONE**

☐ Latex, Reaction:_____ ☐ Tape (adhesives), Reaction:_____

☐ Iodine, Reaction:_____ ☐ IV Contrast Dye, Reaction:_____

Medications (List any medications that you are allergic to and your reaction):_____

_____

Foods (List foods and the reaction):_____

Surgical Procedure(s):	☐ **NONE**	**Year**		**Year**
Gallbladder	(Open)		Tonsillectomy	
Gallbladder	(Laparoscopic)		D & C	
Appendectomy	(Open)		Ear Surgery:_____	
Appendectomy	(Laparoscopic)		Mouth Surgery:_____	
Hysterectomy	(Vaginal)		Heart surgery: CABG/Stents	
Hysterectomy	(Abdominal)		Valve Replacement	
Ovary Surgery:	☐ Ovaries Removed		Pacemaker	
Hernia: ☐ Hiatal ☐ Inguinal ☐ Incisional ☐ Umbilical				
Tubal Ligation			Knee: ☐ Right ☐ Left	
Cesarean Section			Breast Biopsy: ☐ Right ☐ Left	
Colonoscopy			Anti-reflux procedure / Nissen Fundoplication	
Hemorrhoidectomy			Kidney Surgery:_____	
Colon Resection			Back:_____	
Endoscopy/EGD			Other:_____	

Previous Weight Loss Surgery (WLS): _____

(We will need a copy of the Operation Report from your previous weight loss surgery.)

Date of Surgery:_____ Surgeon: _____

List any complications of WLS: _____

Original Weight prior to Surgery: _____❍ Estimated ❍ Actual – Lowest Weight Achieved: _____❍ Estimated ❍ Actual

Anesthesia Problems: Please tell us about any problems that you have had with anesthesia: ☐ **NONE**

☐ Nausea ☐ Heart Stopped ☐ Woke up during procedure

☐ Vomiting ☐ Stopped Breathing ☐ Other:_____

☐ Difficulty Waking Up ☐ Difficulty Urinating

Social History

Do you smoke now? ☐ Yes ☐ No If yes, how many packs per day?_____

Have you smoked in the past? ☐ Yes ☐ No If you have quit, how many years since?_____

For how many years did you use tobacco? _____Years

Do you use snuff or chew? ☐ Yes ☐ No If yes, how frequently do you use?_____

Do you consume alcohol now? ☐ Yes ☐ No

If yes, how many times per week? _____ If yes, how many drinks each time?_____

For how many years have/had you drank alcohol? _____Years

Is anyone concerned about the amount you drink? ☐ Yes ☐ No If you have quit, how many years since?_____

Do you use street drugs now? ☐ Yes ☐ No If yes, what drugs?_____

If yes, how frequently do you use these drugs? _____ If you have quit, how many years since?_____

Could someone help care for you if you were seriously ill? ☐ Yes ☐ No Who?_____

Are there people for whom you are the primary care giver? ☐ Yes ☐ No Who?_____

Family Medical History: (Check all that apply)

Disease	Mother	Father	Siblings (specify brother or sister)	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather
Morbid Obesity							
Diabetes- Age Occurred							
High Blood Pressure							
Stroke- Age Occurred							
Heart Attack- Age Occurred							
Cardiovascular Disease							
Sleep Apnea							
Cancer: Type & Age Occurred							
Death- Age & Cause							
If Still Living, what age							

Name of person completing packet: _____

Relationship to patient: _____

Signature of person completing packet: _____

Signature of patient: _____

Thank you for taking the time to complete the Patient Information Packet.
Please return this packet, a copy of your insurance card(s) front and back, a copy of your photo ID, and your current insurance plan's certificate of insurance to Baptist Health Medical Group Floyd Bariatrics. The office will start processing your information once received and will contact you within the next 30 business days.